Hearing Before the U.S. House of Representatives
Committee on Commerce
Subcommittee on Health and Environment
March 5, 1997
Medicare Home Health Care

Summary of Testimony Provided by James C. Pyles on behalf of the PPS Work Group

This testimony is presented on behalf of the Home Health PPS Work Group, which is a coalition of more than 25 state and national home health associations which are dedicated to the prompt implementation of a prospective payment system for home health services covered by Medicare.

The home health community has developed a prospective payment plan over the past two years which will control the rate of growth in home health expenditures while preserving access to medically necessary services. The plan is based on elements and concepts that have been tested and proven in the context of managed care, the hospice benefit, and a Prospective Payment Demonstration Project approved by HCFA. An earlier version of the plan passed Congress as part of the Balanced Budget Act of 1995 and was reintroduced in the last Congress as H.R. 4229. It has the support of the home health associations from all 50 states and the District of Columbia, as well as three of the largest national home health associations.

The earlier version of the plan, which was part of the Balanced Budget Act of 1995, was scored by CBO as achieving savings of at least $14 billion over 7 years. The plan as contained in H.R. 4229 has been scored by Price Waterhouse as achieving savings in the range of $10 billion over 5 years. The design of the plan, however, permits whatever savings are deemed appropriate for home health services to be achieved under the plan's basic structure.

One significant cause of the high rate of expenditure growth in home health is the antiquated cost reimbursement system that encourages increased costs and visits, penalizes efficiency, and creates opportunities and incentives for fraud and abuse. Within 6 months of enactment, H.R. 4229 would replace cost reimbursement with a prospective payment system that provides incentives and rewards for savings and cost effectiveness. The plan also would reduce the opportunities for fraud and abuse.

By contrast, the Administration's budget proposal retains the antiquated cost reimbursement system with its perverse incentives and then calls for replacing it in October of 1999 with a completely unspecified and untested prospective payment system.

The Administration's proposal also calls for shifting the bulk of the home health benefit to Part B of Medicare, thereby increasing the cost and complexity of administering the home health benefit as well as making any prospective payment plan more difficult to implement and operate.

HEARING BEFORE THE UNITED STATES
HOUSE OF REPRESENTATIVES
COMMITTEE ON COMMERCE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

Wednesday, March 5, 1997

Medicare Home Health Care

TESTIMONY OF JAMES C. PYLES

Mr. Chairman, I am James C. Pyles. I am counsel for the Home Health Services and Staffing Association, which is a member of the Home Health PPS Work Group. I am appearing on behalf of the Work Group, which is a coalition of more than 25 state and national home health associations dedicated to the prompt implementation of a prospective payment system for home health services covered by Medicare.

The PPS Work Group has presented testimony to Congress on this issue on three prior occasions and has worked with Committee staff over the past two years to develop a prospective payment plan for home health services. Therefore, I would like to devote my time today to answering commonly asked questions concerning prospective payment.

1. Does the home health provider community have a better alternative to the Administration's proposal for reducing the rate of expenditure growth for home health services?

Absolutely. Over the past two years, the home health community has fully developed a prospective payment plan which reduces the rate of growth in home health expenditures while preserving access to medically necessary services. As you can see from the enclosed Resolution, that plan, known as the industry's "Revised Unified Plan," has been formally endorsed by the home health associations for all 50 states and the District of Columbia, as well as by three of the largest national home health associations -- the Home Health Services and Staffing Association, the National Association for Home Care, and the Visiting Nurse Associations of America.

An earlier version of that plan passed both Houses of Congress and a Conference Committee as part of the "Balanced Budget Act of 1995" (H.R. 2491).

A revised and improved version of the earlier plan was introduced in the last congressional session by Congresswoman Nancy Johnson as H.R. 4229.

H.R. 4229 would replace cost reimbursement with a prospective payment system within 6 months of the date of enactment. (See attached summary.) That prospective payment system includes

- prospectively established per visit rates;

- subject to annual, aggregate payment limits;

- with savings sharing.

2. Why does the home health community favor prospective payment?

The future of home health depends on the ability of providers to be able to offer an efficient, cost-effective alternative to more expensive types of health care. The current cost reimbursement system penalizes providers who are cost-effective and rewards inefficiency. The current system also creates opportunities and incentives for fraud and abuse.

3. Why is H.R. 4229 preferable to the Administration's proposal?

H.R. 4229 is preferable for many reasons but generally because

a) it immediately replaces the antiquated cost reimbursement system and its incentives for higher costs and higher utilization;

b) it achieves true savings for the Medicare program without shifting costs to other programs or payment sources;

c) it streamlines the administration of the home health benefit and reduces administrative costs for both the government and providers;

d) it does not resort to arbitrary limits or barriers to access for medically necessary services; and

e) it reduces the opportunities and incentives for fraud and abuse.

4. Hasn't the Administration also proposed a prospective payment plan?

No, they have not. The Administration's proposal has three principal components:

a) it retains the antiquated cost reimbursement system, with all of its perverse incentives, until September 30, 1999;

b) it calls for an unspecified prospective payment system which abruptly cuts cost reimbursement by 15% effective October 1, 1999; and

c) it shifts the bulk of home health coverage from Part A to Part B of Medicare.

Thus, the Administration's proposal does not directly address the underlying cause of the high rate of expenditure growth, fails to achieve true savings without shifting costs to other programs, increases administrative costs and complexity, imposes arbitrary limits on coverage, and enhances the opportunities for fraud and abuse. In short, the Administration's plan accepts the status quo and then makes it worse.

HCFA has failed to develop a prospective payment plan for home health despite being directed to do so by Congress in 1987 and again in 1990. Accordingly, it

is unlikely that HCFA will be able to design, develop, and implement a prospective payment plan by October 1999. But even if that were to occur, such a plan would not be the product of years of industry thought and input. Nor would the plan be tested. By contrast, the plan contained in H.R. 4229 has been developed through years of research and input by home health providers of all auspices, and the core concepts of the plan have been the subject of two years of testing in the Phase II Prospective Payment Demonstration Project authorized by Congress and approved by HCFA.

5. Will the home health community's plan achieve scorable savings?

Unquestionably, yes. When the earlier version of the plan passed Congress in 1995, it was scored by the Congressional Budget Office as achieving at least $14 billion in savings over 7 years, despite the fact that CBO applied an unprecedented 67% "behavioral adjustment."

The version of the plan contained in H.R. 4229 has been scored by former CBO officials at Price Waterhouse as achieving savings in the $10 billion range over 5 years.

It is important to understand, however, that whatever savings are determined to be appropriate for home health can be achieved under the plan's basic structure.

6. Why is the home health community opposed to the Administration's Part B shift?

The PPS Work Group is opposed to the Part B shift because:

a) it adds cost and complexity to the home health benefit, due to the fact that Parts A and B have different billing, administrative and appeals processes;

b) it does not any generate any savings for the Medicare program;

c) the prior hospitalization requirement for Part A coverage creates an incentive for unnecessary hospitalizations;

d) it will make fraud and abuse more difficult to detect;

e) it will divert energy and attention away from implementing PPS;

f) it will make any PPS plan more difficult to implement and administer;

g) it will create irresistible pressure to increase the Part B premium and/or impose a 20% copayment on Medicare beneficiaries;

h) it requires workers to pay the same FICA taxes for $82 billion less in Part A health insurance coverage; and

i) it will deprive home health coverage to the 2.1 million Medicare beneficiaries who are not enrolled in Part B.

7. The Administration states that its proposal simply "restores the original split of home health care payments between Parts A and B of Medicare."

That assertion is factually incorrect. The Administration's proposal will transfer 60% to 90% of home health coverage and payments to Part B. As shown by the attached chart, most home health services have been covered and paid under Part A since the beginning of the Medicare program. Thus, the Administration's proposal **reverses rather than restores** the traditional split in payments between Parts A and B.

8. Isn't the Administration correct that imposing a prior hospitalization requirement and visit limits addresses the high growth rate in home health expenditures?

No. Skilled nursing facility services are subject to a prior hospitalization requirement, limits on covered days, and even copayments. Yet, the growth rate in expenditures for those services is nearly twice that of home health services.

9. Isn't the Administration correct that the underlying problem with home health is that Part A was intended to cover "post-acute" care services and that home health services are increasingly chronic care or long term care services?

No. Medicare coverage for both hospital and home health services is limited to acute care services. Both types of services must be "reasonable and necessary for the diagnosis or treatment of illness or injury" and may not include "custodial care." More acute care services are being provided in the home today than ever before. For example, most of the acute care following total hip and knee replacement surgery and coronary artery bypass surgery now takes place in the home. Moreover, as Medicare beneficiaries live longer and their average age increases, home health provides more acute care services to beneficiaries suffering from chronic illnesses (as do hospitals). While the illnesses addressed may be increasingly chronic, the services provided are acute and would have to be furnished in a higher cost setting if they were not furnished in the home.

10. Even if the Part B shift is not supported by any principled rationale, shouldn't Congress consider the proposal because it transfers $82 billion in expenditures out of the Part A Trust Fund and extends the solvency of the Trust Fund for 10 years?

The essence of this argument is "let's damage home health providers so the we don't have to damage other health care providers." We believe that if Congress adopts sound public policy, it should not be necessary to damage any health care providers. The home health community has shown that it is willing and capable of producing its proportionate share of necessary savings. Home health accounts for only 8.7% of total Medicare expenditures and should not be required to shoulder a higher percentage of the savings.

In any event, the Part B shift reduces the cost-effectiveness of the Medicare program and does not improve the quality or amount of services that can be provided. It also only extends the life of the Part A Trust Fund by about one-and-one-half to two years. Accordingly, the limited, one-time advantage conferred by the Part B shift does not justify the short and long term damage it will cause to the home health benefit.

Home health is a popular and humane method of furnishing health care. It has value in the health delivery system by providing a lower cost alternative to high cost treatment options. In fact, home health offers the best opportunity for

providing necessary health care services to members of the post-war baby boom as they become eligible for Medicare coverage. Please help us preserve the home health benefit for current and future Medicare beneficiaries. Enact prospective payment this year.

I would be glad to answer any questions.

Declaration of Support for Implementation of a Prospective Payment System for Medicare Home Health Services

SEPTEMBER 25, 1996

Whereas the health care industry is facing rapid and significant changes both in the delivery of services and its relationships with payors;

Whereas the health care delivery system is increasingly relying on some form of managed care to encourage providers to achieve patient centered, favorable outcomes in the most cost effective manner possible;

Whereas the current structure of cost reimbursement for Medicare home health services is counterproductive to the goals of delivering high quality, cost effective, and medically necessary services;

Whereas the home health industry must move to a prospective payment system to operate more consistently with non-Medicare reimbursement systems;

Whereas the Congress and the Administration have indicated that the rate of expenditure growth in the Medicare home health benefit, combined with the overall financial state of the Medicare program, requires the adoption of some measure to reduce the growth rate in Medicare home health expenditures per patient in future years;

Whereas the home health industry considers copayments, at any level, an unacceptable and improper burden on the infirm, elderly, and disabled who receive Medicare home health services given the significant contributions made by these individuals and their families as primary caregivers in the home setting;

Whereas the home health industry considers proposals to "bundle" home health payment with other Medicare payment, such as hospital services, to be inappropriate and counterproductive in achieving the goal of providing care in the most cost effective setting possible;

Whereas the Congress has requested the home health industry to offer a substitute for copayments and bundling that provides incentives for reducing the rate of expenditure growth while preserving access to medically necessary home health services;

Whereas the home health industry considers the implementation of a prospective payment system to be the appropriate mechanism to address the needs and concerns of patients, the Medicare program, and the home health industry;

Be It Resolved that the following organizations, comprised of the National and State Associations representing the interests of Medicare certified home health agencies, and the patients they serve, nationwide commit their support for the enactment and implementation of a prospective payment system which is entitled "The Revised Unified Plan", as attached hereto.

Signed.

William Eley (Billy)
Alabama Association of Home Health Agencies

Monica Brahler
Illinois Home Care Council

Michelle Reed
Montana Association of Home Health Agencies

Judith McKay
Oregon Association for Home Care

Ritchie Sonner
Maine Home Care Association

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Patricia Mehmken
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Terry O'H. Stark
Pennsylvania Association of Home Health Agencies

Nathalie Russell
Arizona Association for Home Care

Larry Breeding
Iowa Association for Home Care

Ruth Jagodzinski
Home Health Care Association of Nevada

Sandra Torres
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Home Care Association of Arkansas

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Peggy Munro
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Terri Medley
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Jon Blair Hunter
West Virginia Council of Home Health Agencies

Leslie Morgan
Texas Association of Home Health Agencies

Mary Schantz
Missouri Alliance for Home Care

Carol Johnson
Oklahoma Association for Home Care

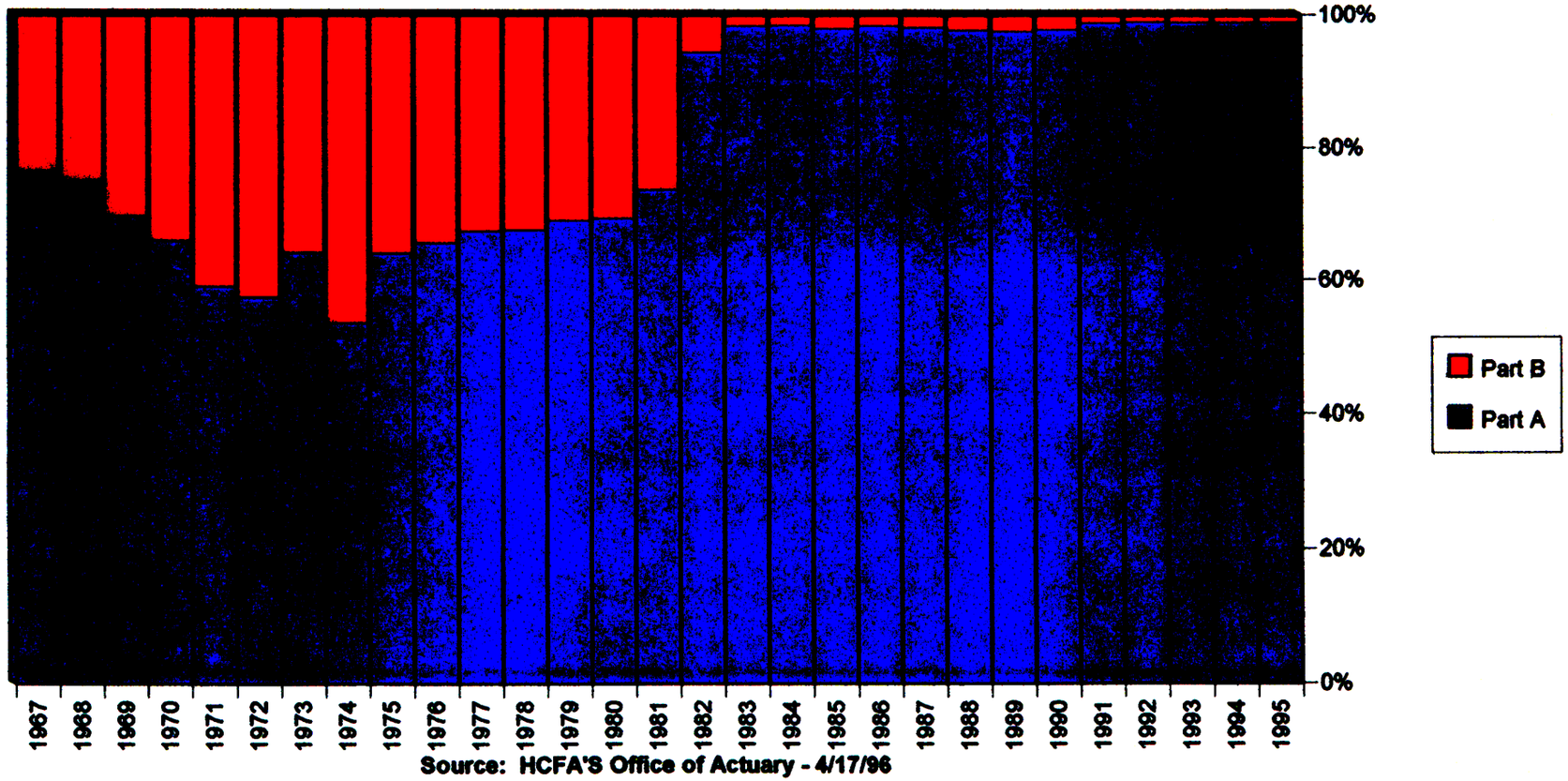
Russell King
Tennessee Homecare Association

Kaye Daniels — Chairman of the Board

Margie Deason
Home Health Care Association of Wyoming

HOME HEALTH SERVICES AND STAFFING ASSOCIATION • NATIONAL ASSOCIATION FOR HOME CARE • VISITING NURSE ASSOCIATION OF AMERICA

"The President's proposal restores the original split of home health care payments between Parts A and B of Medicare." Highlights of the President's Medicare Reform Package.



Source: HCFA'S Office of Actuary - 4/17/96

The PPS Work Group

A Nonpartisan Coalition of National and State Associations Committed to the Prompt Implementation of Medicare Prospective Payment for Home Care

The Home Health Industry's Prospective Payment Proposal Is Preferable to the Part B Shift and Copayments February 11, 1997

- **The home health industry's prospective payment plan was introduced in the last session of Congress by Congresswoman Nancy Johnson (R-CT) as the "Medicare Home Health Services Prospective Payment Amendments of 1996" (H.R. 4229).**

  H.R. 4229 is a revised and improved version of the industry's prospective payment plan which passed Congress in 1995 as part of the "Seven-year Balanced Budget Reconciliation Act of 1995" (H.R. 2491), which was scored by CBO as saving $14.1 billion over 7 years.

- **H.R. 4229 has been endorsed by the home health associations of all 50 states and the District of Columbia, as well as by three of the largest national home health associations -- the Home Health Services and Staffing Association, the National Association for Home Care, and the Visiting Nurse Associations of America.**

- **H.R. 4229 moves home health services from cost reimbursement to prospective payment now!**

  The plan thereby immediately achieves true savings by reducing the growth in Medicare expenditures for home health services without resorting to "gimmicks" such as shifting coverage from Part A to Part B or shifting the cost of an inefficient reimbursement system to Medicare beneficiaries.

- **H.R. 4229 provides the government with control over the rate of growth in home health expenditures while preserving the flexibility for clinical decisions to be made jointly by providers, physicians, and beneficiaries.**

  As in managed care plans, the amount payable to providers will be subject to an annual aggregate cap, but services to patients will not be "micromanaged" by the government. Providers will have an incentive to provide medically necessary care in a more efficient manner, because they will be able to share in the savings that they generate for the government.

- **H.R. 4229 will reduce fraud and abuse in home health care by eliminating the incentives to incur higher costs and provide more visits and by eliminating the opportunity to pass unnecessary costs to the Medicare program.**

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The PPS Work Group

A Nonpartisan Coalition of National and State Associations committed to the Prompt Implementation of Medicare Prospective Payment for Home Care

PPS Work Group
Narrative Explanation of Revised Unified PPS Plan

The Basics of the PPS Plan

The revised PPS plan has three basic components --

(a) prospectively set per visit payments,

(b) subject to prospective aggregate annual limits,

(c) with savings sharing.

Home health agencies are reimbursed the per visit rates for all medically necessary visits regardless of when rendered. Those payments are subject to one (Phase I) or two (Phase II) annual aggregate limits --

(a) a per beneficiary limit or

(b) a per episode limit.

For the first 24 months of the plan's operation, the per beneficiary aggregate limit is applied to **all** per visit payments. After the 24th month of operation of the plan, payment for services furnished during the first 120 days of care will be subject to the per episode limit, and **only** payments for post-120-day care will remain subject to the per beneficiary limit (adjusted to apply to post-120-day services). The 120-day period will be designated an "episode" of care.

Both limits are based on historical costs in a base period trended forward by the home health market basket index. The limits have two distinguishing features. The per episode limit provides for annual adjustments for changes in a home health agency's case mix while the per beneficiary limit does not. The per beneficiary limit is based both on agency-specific and regional historical costs and utilization while the per episode limit is based entirely on regional data.

Home health agencies will not be permitted to retain total per visit payments in excess of the annual aggregate PPS limits. Home health agencies that are able to keep their total per visit payments for the year lower than the relevant aggregate limit will be permitted to share in the savings on a 50-50 basis with the government. The

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maximum amount a home health agency will be permitted to receive under this "savings sharing" mechanism will be 10% of total per visit payments.

Accordingly, aggregate Medicare home health expenditures per patient will be subject to limits which are lower than the projected rate of growth, and home health agencies will have an incentive to achieve additional savings consistent with furnishing quality services. Agencies which are able to keep their per visit costs below the per visit rate will be able to retain 100% of the difference. Agencies that are able to keep their total per visit payments for the year below the relevant aggregate limit will be permitted to receive 50% of the difference, up to 10% of their total per visit payments. These features provide incentives for home health agencies to reduce both costs and utilization. Once the plan is phased in, savings sharing determinations for the first 120 days of care are made using the annual aggregate per episode limits, and-those determinations for services after 120 days are made using the annual aggregate per beneficiary limits. Savings sharing will be computed independently under each limit.

The Secretary shall provide an exceptions process for allowing home health agencies to retain per visit payments in excess of the limits in cases of circumstances beyond the agency's control and extraordinary circumstances. Under no circumstances could the total amount of payments due to exceptions exceed the total amount of savings achieved by the government from home health agencies keeping per visit payments under the aggregate limits.

Within four years of implementation of the prospective payment system set forth in the statute, the Secretary is required to develop and present to Congress a pure per episode prospective payment system, which is to be developed jointly by HCFA, the industry, and consumers. That plan cannot become effective any earlier than one year after its enactment.

Computation of the Per Visit Payment Rate

A per visit payment rate will be established for each of the six types of home health services covered under Medicare. These will be national rates that are adjusted for regional differences in labor costs using the regions designated for the hospital inpatient prospective payment system. These rates will include the cost of non-routine medical supplies.

The per visit payment rates will be established by determining the average amount paid nationally for each type of service during the 12-month cost reporting period ending on or before December 31, **1994** and trending this amount forward by the home health market basket index. The labor-related portion of these rates will be adjusted by the area wage index applicable for the areas specified under the hospital prospective payment system.

Agencies may obtain payments in excess of the per visit rate if they can show that they have incurred costs in excess of the rates. Under no circumstances may the additional payments exceed the relevant annual limits. In order to obtain such payments, agencies must be able to demonstrate that their costs exceed the per visit rates due to events beyond the agencies' control or to extraordinary circumstances.

Computation of the Per Beneficiary Limits

The aggregate per beneficiary limits are computed by multiplying the average cost of providing services to beneficiaries in the base period, trending that amount forward by the home health market basket index, and multiplying the result by the unduplicated number of patients served by the home health agency in the current year.

The calculation would be performed in the following steps:

1. the average cost per visit in fiscal year 1994 would be determined both for the specific agency and for the census region;

2. those amounts would be trended forward by the home health market basket index;

3. those amounts, in turn, would be multiplied by the average per patient utilization rates both for the specific agency and for the census region for fiscal year 1995;

4. a blended per beneficiary limit would be calculated comprised 75% of the agency-specific per beneficiary cost and 25% of the census region per beneficiary cost (this ratio would change to 50% agency-specific and 50% census region costs after the plan has been in effect for 12 months);

5. an aggregate annual per beneficiary limit would be computed by multiplying the applicable blended per beneficiary limit by the particular home health agency's unduplicated patient census for the current year;

6. during the first 24 months that the plan is in effect, the per beneficiary limit will be based on the average base year cost per beneficiary for all services; thereafter, the per beneficiary limit will be based only on the average base year cost per beneficiary for services furnished after 120 days.

Computation of the Per Episode Limits

The per episode limits apply only after the first 24 months of the plan's operation and only to the first 120 days a patient is under a plan of treatment. These limits are based on the average cost of an "episode" of care in a region (as defined under the hospital prospective payment system) during the base period, trended forward by the home health market basket index. These limits are subject to a case mix adjuster, which is intended to reduce incentives for avoiding sicker patients with more complex needs.

The per episode limit calculation would be performed in the following steps:

1. The following calculation is made for each of the 18 case mix categories in a case mix adjustor which was adopted from the Phase II Prospective Payment Demonstration Project:

    a. for each region during the fiscal year 1995 base period, the mean number of visits would be determined for each category of covered services provided during the first 120 days after a patient is admitted (an episode);

    b. the mean number of visits per service category is then multiplied by the per visit rate for that service category in the current year;

2. the number of episodes in a current year falling within each of the 18 case mix categories is then multiplied by the limit for that category; and

3. those products are summed to arrive at the aggregate per episode limit.

Savings Sharing

Home health agencies may receive 50% of the amount by which their total payments are less than the aggregate limits up to 10% of total payments. Total payments will be compared to the per beneficiary aggregate limit during the first 24 months until the per episode limits are computed. After 24 months, total payments for services provided during the first 120 days will be subject to the aggregate per episode limit. Total payments for services after 120 days will be subject to the per beneficiary limit. In order to qualify for savings sharing under the per beneficiary limit, a home health agency's average per beneficiary payment in the current year would have to be less than 125% of the average payment rate for the census region.